IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0153/2024

Police No: 24 59775

CORONERS' FINDINGS

ROAD DEATH 28 OF 2024

Section 34 of the ***Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a 61-YEAR-OLD CAUCASIAN MALE** and without holding an inquest, find that he was born on **11 July 1962** and that his **death occurred on 18 June 2024, at Lambrick Avenue, Johnston in the Northern Territory.**

Introduction:

These findings concern the 28th road death out of 60 road deaths for 2024.

This was the death of a cyclist. Cyclists account for 2% of road fatalities.

This 61-year-old experienced cyclist was riding a road bike fitted with excellent quality bicycle lighting. He was wearing a helmet and darker clothing. He was riding in the early morning when it was dark. Although there was a bike path, he was riding on the road which he was legally entitled to do.

He approached a Stuart Highway intersection. On approach, a slip lane for left hand turns forms. However, he was travelling straight through, so he was riding on the right-hand side of the slip lane and just to the left of the lane which proceeded straight ahead.

Several factors made it difficult for approaching drivers to see the cyclist. A streetlight was malfunctioning, and the cyclist was in a short, poorly lit/unlit, section of the road. As he approached the intersection, the traffic lights turned red and a car to his right braked. There were, therefore, several red lights (traffic lights, brake lights and cyclists rear light) which made it difficult to discern the cyclist's rear light.

An approaching vehicle was travelling at the 80 km/h speed limit intending to turn left on the Stuart Highway. The sober and licenced driver (Driver 2) conducted a check of his left side mirror and veered into the slip lane. He did not see the cyclist until it was too late. He braked heavily but the crash could not be avoided.

This was another tragic loss of life.

Cause of death:

1(a)	Disease or condition leading directly to death:	**Multiple blunt force injuries**
1(b)	Morbid conditions giving rise to the above cause:	**Multiple motor vehicle crash (cyclist)**

Following an autopsy on 18 June 2024, the Forensic Pathologist commented:

Summary of main pathological findings -

- External examination showed:
  - The body of an adult male clad in cycling gear with evidence of medical intervention with defibrillator pads on the chest, bilateral anterior intercostal drains, pelvic binder and bilateral tibial intraosseous lines. A damaged helmet was also received in the body bag.
  - Multiple abrasions present of the face, the lower abdomen, back, lower legs and arms.
  - A laceration of the right ankle posteriorly.
- Post-mortem CT scan showed:
  - Extensive subarachnoid haemorrhage but no calvarial or facial fractures.
  - Fusion of the 5th and 6th cervical vertebral bodies but no cervical spine fracture.
  - Large bilateral haemothoraces.
  - Right 5th rib fracture and sternal fracture, possibly resuscitation-related.
  - Fracture/dislocation of the 3rd and 4th thoracic vertebra with significant compromise of vertebral canal.
  - Crush fracture of 1st lumbar vertebrae and of anterior inferior endplate of 5th lumbar vertebra.
  - Possible avulsion fracture of proximal left ulna.
- Toxicological analysis showed no alcohol or any of the drugs listed on the laboratory's attached Scope of Analysis were detected.

Comments-

- The opinion as to the cause of death is based on the available police and medical information, and a post-mortem examination including ancillary investigations.
- I have no reason to believe that the information available and findings made during external examination of the body that the death was due to any other cause other than the apparent motor vehicle versus cyclist collision.

Circumstances:

The cyclist was married with two children. He had served in the RAAF for 23 years but was privately employed at the time of his death.

On 18 June 2024, at about 5.40 am, he left his home to cycle to work. He was dressed in a white lycra top (with black spots) and black bicycle shorts. He wore a black helmet and was carrying a black/white backpack on his back.

His bicycle was fitted with a Blackburn Dayblazer 1100 solid white front light, Garmin 130 trip computer and Garmin Varia RTL515 red rear taillight. The Garmin Varia RTL515 taillight is fitted with a rear-view radar that can pair with compatible devices, including the Garmin 130 trip computer. It provides a visual and audible alert to cyclists of motorists approaching from up to 140 metres behind. There are multiple taillight modes available including 'Solid (default)' mode where the taillight has a solid high light intensity which flashes when the radar detects a vehicle approaching with the purpose of alerting oncoming drivers to the bike.

Around the same time, Driver 1 left work after a 12-hour night shift to travel home. He was driving a NT registered, MG 4 hatchback.

Between 5.40 - 5.45 am, Driver 2 left his home to travel to work. He was driving a NT registered white Toyota Landcruiser.

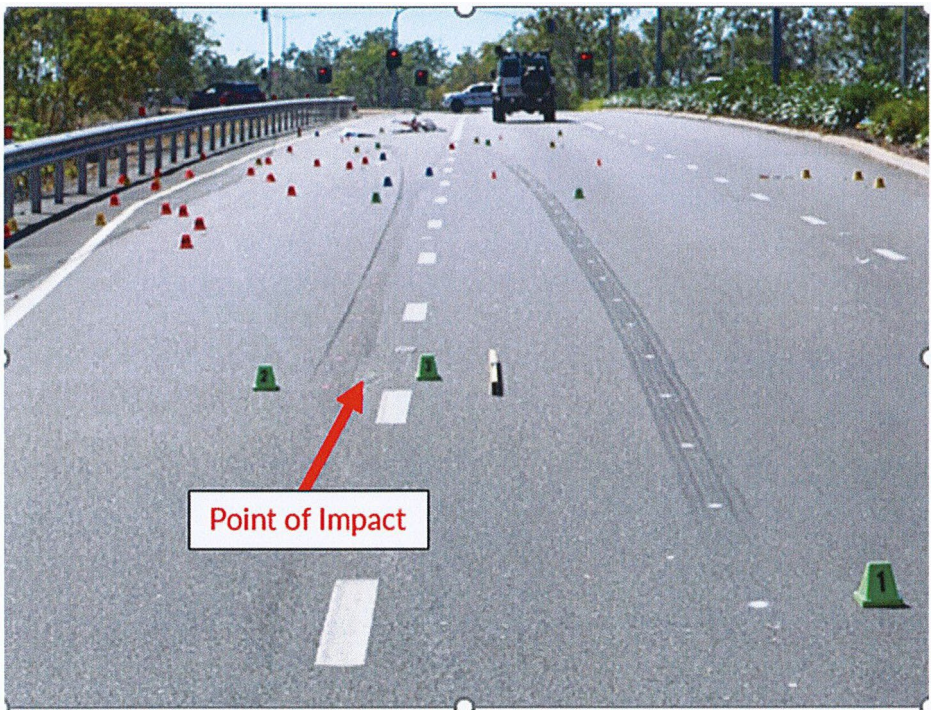
At about 5.54 am, the cyclist was captured on Department Logistics and Infrastructure (DLI) CCTV cameras approaching the Lambrick Avenue/Stuart Highway intersection. A short time later the CCTV camera panned away. However, he continued to ride on the broken white line between the left turn lane and the middle lane of Lambrick Avenue as though to proceed through the lights and cross the Stuart Highway.

At this time the streetlight near where the crash occurred was not illuminated and at 5.54 am, traffic lights were red at the Lambrick Avenue and Stuart Highway intersection.

When Driver 1 approached the intersection, he only saw the cyclist when he was very close. He told police he got a shock when he saw him. Driver 1 was travelling at 80 km/h, the posted speed limit, and passed the cyclist within a metre, but did not need to swerve. After he passed the cyclist, Driver 1 continued towards the Lambrick Avenue/Stuart Highway intersection.

Driver 2 was travelling at 80 km/h not far behind Driver 1. Driver 2 started to prepare to turn left into the left turning lane. He told police that he had his left hand on the gear stick and foot off the accelerator. At this time the cyclist was still positioned on the broken white line, dividing the middle and left turn lane. Driver 2 said that he had just completed a left mirror check, as part of changing lanes, when he saw a "big white blob" in front of his left headlight, and he applied heavy braking.

The front wheels of Driver 2's Landcruiser locked up and the Landcruiser skidded for 4.53 metres and crashed into the rear of the cyclist. At impact the Landcruiser was travelling at 75 km/h. The cyclist was thrown onto the bonnet of the Landcruiser. The Landcruiser skidded to a stop 38.71 metres from where the skid commenced and the cyclist came to rest on the roadway 5 meters in front of the Landcruiser.



Driver 1 heard the screech of tires. He knew something wasn't right, so he reversed approximately 10 meters. He saw the cyclist lying on the ground in the left turning lane. He conducted Cardiopulmonary Resuscitation (CPR) but saw that the cyclist's eyes were open, he was not moving, he was not breathing and he did not have a pulse.

Driver 2 immediately called 000 at 5.56 am and stayed on the phone and relayed CPR advice to Driver 1.

A short time later an off duty Detective Sergeant of Police was driving past and stopped to assist Driver 1 with the CPR which they continued until the Northern Territory Fire Service arrived and a defibrillator was fitted.

St John Ambulance Paramedics arrived at 6.06 am and they continued treatment and CPR, however, the cyclist could not be revived. At 6.33 am the Paramedics ceased CPR and the cyclist was declared deceased at 6.34 am.

Road Features and Conditions:

The section of Lambrick Avenue, Johnston, where the crash occurred is a sealed single lane carriageway that rises and forms into three lanes towards the Stuart Highway intersection. The original lane continues for traffic travelling towards Howard Springs and those turning right onto the Stuart Highway. A second right turn lane forms for those turning right onto the Stuart Highway and a left lane forms for those turning left onto the Stuart Highway. A concrete/garden median separates traffic travelling to and from the Stuart Highway.

At the area of impact, the lanes are separated by broken white lines that become solid closer to the intersection. A 2-laned sealed bitumen bicycle path is located on the northern side of Lambrick Avenue

Weather and Lighting Conditions:

There were nil adverse weather conditions reported. At the time of crash, conditions were described as dark.

There is street lighting in the area however, CCTV showed that the light illuminating the area of the crash was faulty at the time of the crash. It would periodically light up and turn off. At the time the crash occurred the light was off and not illuminating the road area.

The Department of Logistics and Infrastructure (formerly Department of Infrastructure Planning and Logistics (DIPL)) confirmed that a defect had been raised for the streetlight (21387), positioned to illuminate the opposite (inbound) lane of Lambrick Avenue, but not for the streetlight in question (21654). Both have since been rectified.

Vehicle Inspection:

The Toyota Landcruiser wagon was inspected by Motor Vehicle Registry Licensed Inspector at the Wishart MVR test sheds on 21 June 2024.

The vehicle was found to be unroadworthy with several defects including, a rear brake imbalance. As a result, a defect notice was issued (No. MV43801).

On 5 July 2024, a Detective Senior Constable and certified light vehicle mechanic, also inspected the vehicle at the Peter McAulay Centre workshops. He identified several issues with the braking system of the vehicle.

It is the opinion of the investigators that none of the defects contributed to the crash.

Tests and/or Calculations Conducted:

Driver 2 was subjected to a roadside breath test and roadside drug test, which returned negative results.

A terrestrial survey was conducted at the scene by Motor Crash Investigation Unit (MCIU) investigators. The right tyre friction mark left by the Toyota Landcruiser was 38.71 metres in length. Analysis confirmed that the Toyota Landcruiser commenced the skid 4.53 metres prior to hitting the cyclist.

On 21 June 2024, MCIU investigators conducted friction supply testing in the Toyota Landcruiser wagon which was not fitted with an Anti-lock Braking System. While a four wheel lock up would be expected under heavy braking, the test confirmed that only the front wheels locked up and the rear wheels continued rolling.

A speed calculation revealed:

- The Toyota Landcruiser was calculated at travelling at a minimum speed of 80 km/h when the vehicle commenced the skid.
- The Toyota Landcruiser was calculated at travelling at a minimum speed of 75 km/h when it hit the cyclist.

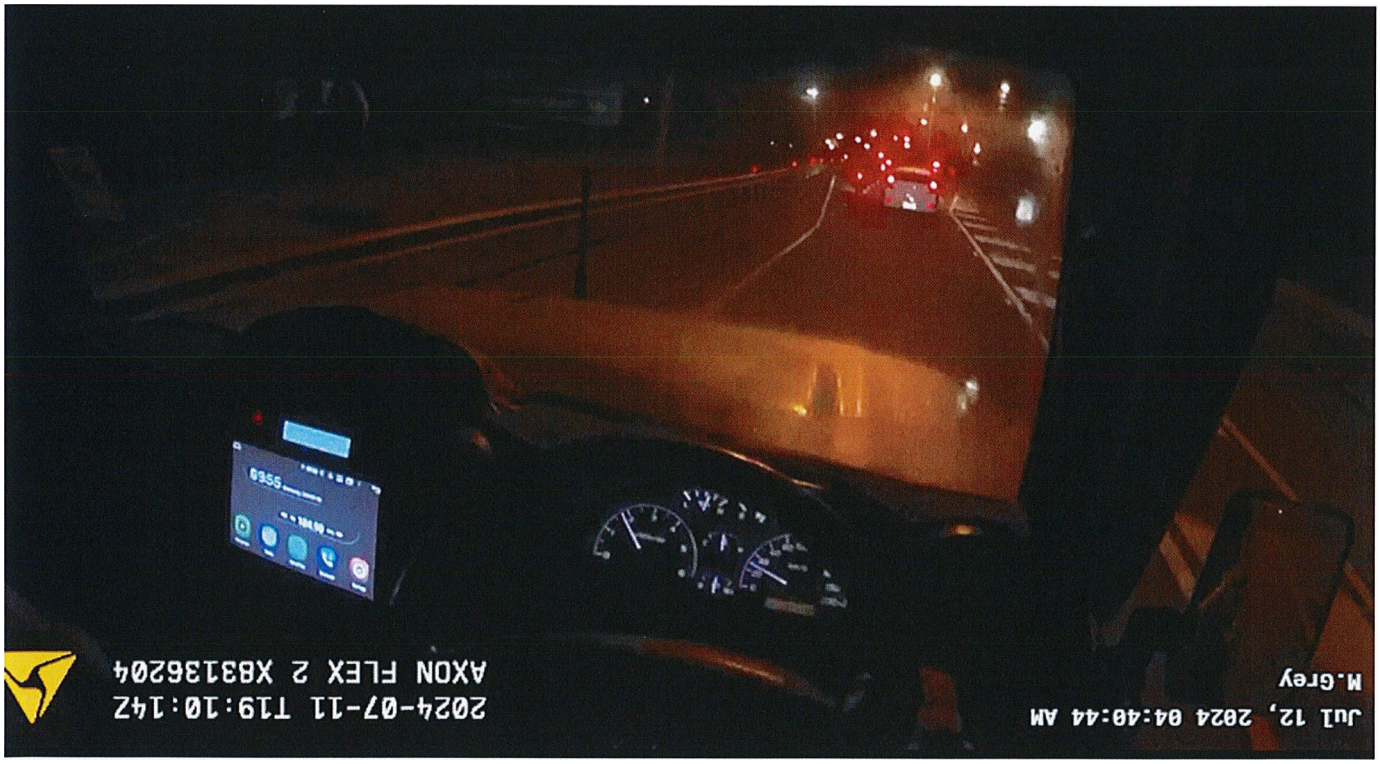
The cyclist was difficult to see because:

- It was dark where the crash occurred due to the malfunctioning streetlight.
- His clothing and backpack were mostly dark.
- The driver did not expect a to see a cyclist.
- Nighttime recognition is more difficult.
- His single taillight was difficult to discern, amongst other red lights, and given limited other visual information (because it was dark).

In all the circumstances, by the time an average driver travelling at 80 km/h could have identified the cyclist, there was not enough distance to avoid the crash. In fact, Driver 2 braked quicker than the average driver, but still the crash could not be avoided.

On 12 July 2024, MCIU investigators conducted a re-enactment at the Lambrick Avenue crash scene using the Toyota Landcruiser wagon. The re-enactment consisted of the Landcruiser, a small white hatchback vehicle of similar size to Driver 1's vehicle, and a bicycle with a red flashing taillight. Although the re-enactment gave a driver point of view in similar conditions, there were variables that were unable to be replicated to the day of the crash. Therefore, the data collected could not be referenced in terms of the Crash Analysis Report. The re-enactment was recorded on police Body Worn Video (BWV) for the purpose of obtaining the point of view of Driver 2 in the lead up to the crash in similar conditions.

The re-enactment demonstrated the image overload Driver 2 would have experienced with reference to the red bicycle taillight in contrast to the red traffic lights and break lights. It demonstrates just how difficult it was for Driver 2 to identify the cyclist (to the left of the braking car).



This re-nactment still image and all other images courtesy of Major Crash Investigators

Opinion as to the Cause of Crash:

Based on scene evidence, witness statements and Police investigations, the Motor Crash Investigator concluded:

- The cyclist was legally riding a road bicycle on the road in the dark with an operating headlight and taillight.
- He was wearing a bicycle helmet and mostly dark clothing and backpack.
- He rode towards the large Stuart Highway intersection, over a complex set of lane splits and near the centre lane.
- The lights at the intersection of Lambrick Avenue and Stuart Highway were red and it is likely the cyclist's single rear taillight may have 'blended' in with the traffic light and red taillights.
- The streetlight positioned near the point of impact was not illuminated. This would have resulted in a significant reduction of lighting in the area and, along with the relatively darker clothing worn by the cyclist, would have made it harder for a driver to see him and his bicycle.
- Driver 2 did not see the cyclist until after he commenced his lane change into the left turning lane.
- Driver 2 was travelling at 80 km/h (the speed limit) and braked heavily. Although the Landcruiser was unroadworthy, due to a rear brake imbalance and had a reduction in

its overall braking capability, this is not a contributing factor. From the point at which Driver 2 saw the cyclist (or any similarly placed driver could have seen the cyclist), the crash would still have occurred even if braking efficiency had been at 100%.

- The cyclist's decision to stay on the road (which he was legally entitled to do), instead of using the bike path, was a contributing factor.

Prosecution:

Police referred this matter to the Director of Public Prosecutions (DPP) for an opinion. The DPP advised that Driver 2 could be charged with drive unsafe motor vehicle. The DPP further considered the matter after the receipt of the Crash Analysis Report. On 18 December 2024, the DPP advised that no further charges in relation to the crash could be made out.

Decision not to hold an inquest:

Under section 16(1) of the *Coroners Act* 1993 I decided not to hold an inquest because the investigations into the death disclosed the time, place and cause of death and the relevant circumstances concerning the death. I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date. The circumstances do not require a mandatory inquest because:

- The deceased was not, immediately before death, a person held in care or custody; and
- The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
- The identity of the deceased is known.